Appendix 11
Restorative Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Amalgam Restorations (including polishing):				
02110	Amalgam - 1 surface, primary	No	All	Once per tooth, per year, per provider.+ (tooth letters A-T, SN only)
02120	Amalgam - 2 surfaces, primary	No	All	Once per tooth, per year, per provider.+ (tooth letters A-T, SN only)
02130	Amalgam - 3 surfaces, primary	No	All	Once per tooth, per year, per provider.+ (tooth letters A-T, SN only) (Four surface amalgams may be billed under this code.)
02140	Amalgam - 1 surface, permanent	No	All	Once per tooth, per 3 years, per provider.+ (tooth numbers 1-32, SN only)
02150	Amalgam - 2 surfaces, permanent	No	All	Once per tooth, per 3 years, per provider.+ (tooth numbers 1-32, SN only)
02160	Amalgam - 3 surfaces, permanent	No	All	Once per tooth, per 3 years, per provider.+ (tooth numbers 1-32, SN only) (Four surface amalgams may be billed under this code.)

Key:

\+ - Limitation may be exceeded if narrative on claim demonstrates medical necessity for replacing a properly completed filling, crown, or adding a restoration on any tooth surface. Limitation may be exceeded for non-prior authorized crowns by indicating medical necessity in a narrative on the claim.

Appendix 11
Restorative Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Resin Restorations:				
02330	Resin - 1 surface, anterior	No	All	Once per three years, per provider, per permanent tooth.+ Once per year, per provider, per primary tooth.+ Allowed for Class I and Class V only. (tooth numbers 6-11, 22-27, C-H, M-R, SN only)
02331	Resin - 2 surfaces, anterior	No	All	Once per three years, per provider, per permanent tooth.+ Once per year, per provider, per primary tooth.+ Allowed for Class III only. (tooth numbers 6-11, 22-27, C-H, M-R, SN only)
02332	Resin - 3 surfaces, anterior	No	All	Once per three years, per provider, per permanent tooth.+ Once per year, per provider, per primary tooth.+ Allowed for Class III and Class IV only. (tooth numbers 6-11, 22-27, C-H, M-R, SN only)
02335	Resin - 4 or more surfaces or involving incisal angle (anterior)	No	All	Once per three years, per provider, per permanent tooth.+ Once per year, per provider, per primary tooth.+ Allowed for Class IV only. (tooth numbers 6-11, 22-27, C-H, M-R, SN only) Must include incisal angle. Four surface resins may be billed under 02332, unless an incisal angle is included.

Key:

\+ - Limitation may be exceeded if narrative on claim demonstrates medical necessity for replacing a properly completed filling, crown, or adding a restoration on any tooth surface. Limitation may be exceeded for non-prior authorized crowns by indicating medical necessity in a narrative on the claim.

Appendix 11
Restorative Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
02380	Resin - 1 surface, posterior primary	No	All	Once per year, per provider, per tooth.[+] (tooth letters A, B, I, J, K, L, S, T, SN)
02381	Resin - 2 surfaces, posterior primary	No	All	Once per tooth, per year, per provider.[+] (tooth letters A, B, I, J, K, L, S, T, SN only) This resin code will be paid at the same rate as an equivalent amalgam.
02382	Resin - 3 or more surfaces, posterior primary	No	All	Once per tooth, per year, per provider.[+] (tooth letters A, B, I, J, K, L, S, T, SN only) This resin code will be paid at the same rate as an equivalent amalgam.
02385	Resin - 1 surface, posterior permanent	No	All	Once per three years, per provider, per tooth.[+] (tooth numbers 1-5, 12-21, 28-32, SN)
02386	Resin - 2 surfaces, posterior permanent	No	All	Once per tooth, per 3 years, per provider.[1] (tooth numbers 1-5, 12-21, 28-32, SN) This resin code will be paid at the same rate as an equivalent amalgam.
02387	Resin - 3 or more surfaces, posterior permanent	No	All	Once per tooth, per 3 years, per provider.[1] (tooth numbers 1-5, 12-21, 28-32, SN) This resin code will be paid at the same rate as an equivalent amalgam.
Other Restorative Services:				
02910	Recement inlay	No	All	Tooth numbers 1-32, SN only.
02920	Recement crown	No	All	Tooth numbers 1-32, A-T, SN.
02930	Prefabricated stainless steel crown (SSC) primary tooth	No	All	Tooth letters A-T, SN only (once per year, per tooth).[+]
02931	Prefabricated stainless steel crown (SSC) permanent tooth	No	All	Tooth numbers 1-32, SN only (once per five years, per tooth)[+]

Key:

[1] - Retain records in recipient files regarding nature of emergency.

\+ - Limitation may be exceeded if narrative on claim demonstrates medical necessity for replacing a properly completed filling, crown, or adding a restoration on any tooth surface. Limitation may be exceeded for non-prior authorized crowns by indicating medical necessity in a narrative on the claim.

Appendix 11
Restorative Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
02932	Prefabricated resin crown	Yes (> age 20)	All	Tooth numbers 6-11, 22-27, D-G, SN (once per year, per primary tooth; once per five years, per permanent tooth). (Composite crown may be billed under this code). Limitation exceeded with narrative for children+, and with prior authorization for adults > age 20.*
02933	Prefabricated stainless steel crown with resin window	Yes (> age 20)	All	Tooth numbers 6-11, D-G, SN only (once per year, per primary tooth; once per five years, per permanent tooth). Limitation exceeded with narrative for children+, and with prior authorization for adults > age 20.*
Upgraded Cast Crown:				
W7126	Upgraded crown	Yes	All	Tooth numbers 1-32, A-T, SN (once per year, per primary tooth; once per five years, per permanent tooth*). No dentist is obligated to provide this service.
02940	Sedative filling	No	All	Not allowed with pulpotomies, permanent restorations, or endodontic procedures (tooth numbers 1-32, A-T, SN only).
02951	Pin retention - per tooth, in addition to restoration	No	All	Tooth numbers 1-32, SN only (once per three years per tooth).+

Key:

* - Frequency limitation may be exceeded only with prior authorization.

\+ - Limitation may be exceeded if narrative on claim demonstrates medical necessity for replacing a properly completed filling, crown, or adding a restoration on any tooth surface. Limitation may be exceeded for non-prior authorized crowns by indicating medical necessity in a narrative on the claim.

Appendix 11
Restorative Services
(continued)

COVERED SERVICES

FREQUENCY LIMITATIONS

Wisconsin Medicaid limits the frequency of restorations on each tooth. The limitations may be exceeded only if a narrative on the claim demonstrates the medical necessity for replacing a properly completed restoration. Claims for a replacement restoration done in less than the allowable time frame that fail to include a statement indicating why the restoration was replaced are denied.

STANDARDS AND GUIDELINES

The standards and guidelines listed below, along with any limitations listed in the preceding pages, are required to be followed when providing restorative services:

- A restoration is considered a two or more surface restoration when two or more actual tooth surfaces are involved, *whether they are connected or not*.
- Any single or combination of restorations on one surface of a tooth is considered as one surface for reimbursement purposes.
- For billing purposes, count the total number of tooth surfaces restored and list the surface letters on the claim, *even when unrelated surfaces are restored*.
- Services not reimbursable as separate procedures are:
  1. Services considered part of the restoration, including:
     a. Base, copalite, or calcium hydroxide liners placed under a restoration.
     b. The acid etching procedure for composite restorations.
  2. Local anesthesia which is included in the restorative service fee.
- Charges for pulpotomies must be itemized separately on the dental claim form. They are not included in the reimbursement for restorations.

AMALGAM RESTORATIONS

Amalgam restorations:

- Are a covered service of Wisconsin Medicaid.
- Can be placed on any primary or permanent tooth.

RESIN RESTORATIONS

Wisconsin Medicaid covers resin restorations and reimburses most resin codes at the same rate as an equivalent amalgam.

TEMPORARY SEDATIVE FILLINGS

Temporary sedative fillings in conjunction with root canal procedures are paid for as part of the root canal procedure and are not separately billable. They are not considered to be a small base before placement of a permanent restoration.

TOOTH SURFACES

The following letters are the only ones accepted by Wisconsin Medicaid for the identification of tooth surfaces:

Anterior Teeth (Centrals, Laterals, Cuspids)

Mesial	(M)	Facial	(F)
Incisal	(I)	Lingual	(L)
Distal	(D)	Gingival	(G)

Appendix 11
Restorative Services
(continued)

Posterior Teeth (Pre-molars/Bicuspids, Molars)

Mesial	(M)	Buccal	(B)
Occlusal	(O)	Lingual	(L)
Distal	(D)	Gingival	(G)

Wisconsin Medicaid only pays per unique surface regardless of location. When gingival (G) is listed with a second surface, such as BG, BFG, DG, FG, LG, MG, they are considered a single surface. Also, "FB" is considered one surface since the two letters describe the same tooth surface.

PRIOR AUTHORIZATION

CROWNS PA is required for recipients 21 years of age and older for composite/prefabricated resin crowns or stainless steel crowns with resin windows on specific anterior teeth.

UPGRADED CROWNS Wisconsin Medicaid reimburses dentists for providing upgraded crowns. Due to fiscal limitations, and federal and state regulations, the following policy regarding these services has been established:

- PA is always required.
- Reimbursement is at the maximum fee for the "standard" stainless steel crown.
- Reimbursement must be accepted as payment in full.
- Each dental office that provides the service must have written criteria based on medical necessity to determine who will receive the upgraded service.
- The form in Appendix 25 of this handbook must be completed and attached to the PA/DRF and PA/DA.
- All criteria must be applied consistently to all Medicaid recipients.

No dentist is under any obligation to provide upgraded crowns.

RADIOGRAPH DOCUMENTATION Providers must include a periapical radiograph of the involved tooth or teeth with any request for PA for crowns.

ADDITIONAL INFORMATION

In addition to this summary, a provider needs to refer to:

- The preceding pages for a complete listing of Wisconsin Medicaid covered restorative services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.

Appendix 12
Endodontic Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Pulpotomy:				
03220	Therapeutic pulpotomy (excluding final restoration)	No	All	Once per tooth per lifetime. Primary teeth only. (tooth letters A-T, SN only)
Root Canal Therapy (including treatment plan, clinical procedures, and follow-up care:				
03310	Anterior (excluding final restoration)	Yes, > age 20	All	Normally for permanent anterior teeth. May be used to bill a single canal on a bicuspid or molar (tooth numbers 2-15, 18-31, SN only, once per tooth, per lifetime). Not allowed with sedative filling.
03320	Bicuspid (excluding final restoration)	Yes, > age 20	All	Normally for permanent bicuspid teeth May be used for two canals on a molar (tooth numbers 2-5, 12-15, 18-21, 28-31, SN only, once per tooth, per lifetime). Not allowed with sedative filling.
03330	Molar (excluding final restoration)	Yes	All	Not covered for third molars. Permanent teeth only (tooth numbers 2, 3, 14, 15, 18, 19, 30, 31, SN only, once per tooth, per lifetime). Not allowed with sedative filling.
03351	Apexification/recalcification - (apical closure/calcific repair of perforations, root resorption, etc.)	No	< 21	Permanent teeth only (tooth numbers 2-15, 18-31, SN only). Not allowable with root canal therapy. Bill the entire procedure under this code.

Appendix 12
Endodontic Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
W7116	Open tooth for drainage	No	All	Tooth numbers 2-15, 18-31, SN. *Emergency only.* Limit of $50.00 reimbursement per day for all emergency procedures done on a single day. Narrative required to override the limitations. Not billable with root canal therapy or pulpotomy on same date of service. Should be followed with a prior authorization request for a root canal.
Periapical Services:				
03410	Apicoectomy/periradicular surgery - anterior	Yes, unless provided to a hospital inpatient	All	Permanent anterior teeth only (tooth numbers 6-11, 22-27, SN only). Not payable with root canal therapy on the same date of service. Code does not include retrograde filling. Include retrograde filling on prior authorization request for apicoectomy and on claim for billing.
03430	Retrograde filling - per root	Yes, unless provided to a hospital inpatient		Permanent anterior teeth only (tooth numbers 6-11, 22-27, SN only). Not payable with root canal therapy for the same date of service. Include retrograde filling on prior authorization request for apicoectomy and on claim for billing. Apicoectomy does not include retrograde filling.

Appendix 12
Endodontic Services
(continued)

COVERED SERVICES

STANDARDS FOR ROOT CANAL THERAPY

The following guidelines must be followed when providing endodontic services:

- The standard of acceptability employed by Wisconsin Medicaid for endodontic procedures requires that the canal(s) be completely filled apically and laterally.
- Root canal therapy for permanent teeth includes:

1. Diagnosis.
2. Extirpation.
3. Treatment.
4. Progress radiographs.
5. Filling and obliteration of root canals.
6. Temporary fillings.

NONCOVERED SERVICES

When the root canal filling does not meet Wisconsin Medicaid treatment standards:

- Wisconsin Medicaid can require the procedure to be redone at no additional Wisconsin Medicaid reimbursement.
- Any reimbursement already made may be recouped after the Wisconsin Medicaid dental consultant reviews the circumstances.

Sargenti filling material and other materials not accepted by the federal Food and Drug Administration are not accepted by Wisconsin Medicaid.

RADIOGRAPHS

A post-treatment radiograph *is required* for all root canal therapy and can be reimbursed separately.

OPEN TOOTH FOR DRAINAGE

Emergency treatment for recipients needing root canal therapy can be provided without prior authorization (PA) using code W7116, (Open Tooth for Drainage). This allows the dentist to relieve pain and/or extirpate the tooth in anticipation of proceeding with a root canal. A PA request for a root canal should be sent immediately.

INTERRUPTED ROOT CANAL THERAPY

A dentist may bill "open tooth for drainage" and "sedative filling" to receive reimbursement when root canal therapy begins and the recipient fails to return for subsequent visits or becomes ineligible.

REFERRALS

General dentists should not refer Medicaid recipients to endodontists, unless the recipient has a restorative dentist to provide restoration of the teeth.

General dentists referring a root canal procedure to an endodontist should complete the appropriate sections of the Prior Authorization Dental Attachment (PA/DA) form and send it to the endodontist with the referral.

General dentists referring Medicaid recipients to endodontists need to supply the endodontist with:

- Minimum of two bitewing x-rays.
- Oral charting of missing teeth.
- Treatment plan including plan for involved tooth.
- Oral hygiene status.

Appendix 12
Endodontic Services
(continued)

- Attendance information.
- Date and reason for any extractions within the past three years.

PRIOR AUTHORIZATION

PRIOR AUTHORIZED ROOT CANAL SERVICES

PA is required for all anterior, bicuspid, and molar teeth for recipients 21 years old and older. For recipients under age 21, PA is only required for molar endodontic procedures.

Up to three root canals can be approved, based on clinical appropriateness and restorability of the teeth. Root canals are limited to once per tooth, per lifetime, unless extenuating circumstances exist. Root canal therapy is not covered on third molars.

APICOECTOMY AND RETROGRADE FILLING

Apicoectomy and retrograde fillings are limited to anterior teeth only.

Providers must include a periapical with any request for PA for apicoectomy and retrograde filling.

Providers must include a request for a retrograde filling separately with the PA requests for an apicoectomy.

PA is not required when the apicoectomy and retrograde filling services are provided to a hospital inpatient.

CRITERIA FOR APPROVAL

The recipient qualifies for root canal therapy if:

For procedure code 03310

1. No more than three anterior teeth require root canal therapy, and no anterior tooth in the same arch is missing or indicated for extraction. The recipient must have adequate posterior occlusion per Wisconsin Medicaid criteria and would not be a partial denture candidate. If the recipient already qualifies for a partial denture due to missing anterior teeth in the same arch, or inadequate posterior occlusion, the request for root canal therapy is denied and the provider is asked to submit a request for a partial denture. The provider has the option to complete the root canal therapy on the indicated tooth or teeth at the recipient's expense.

2. The tooth is an abutment tooth for a fixed bridge or an anchor tooth for a partial denture and the bridge or partial is serviceable and functional, as determined by the Wisconsin Medicaid dental consultant.

3. Good recipient attendance record.

For procedure codes 03320 and 03330

1. No more than two posterior teeth require root canal therapy, and no anterior tooth in the same arch is missing or indicated for extraction. The recipient must have adequate posterior occlusion per Wisconsin Medicaid criteria and would not be a partial denture candidate. If the recipient already qualifies for a partial denture due to missing anterior

Appendix 12
Endodontic Services
(continued)

teeth in the same arch or inadequate posterior occlusion, the request for root canal therapy is denied and the provider is asked to submit a request for a partial denture. The provider has the option to complete the root canal therapy on the indicated tooth or teeth at the recipient's expense.

2. The tooth is an abutment tooth for a fixed bridge or an anchor tooth for a partial denture and the bridge or partial is serviceable and functional, as determined by the Wisconsin Medicaid dental consultant.

3. One posterior tooth requires root canal therapy and no other anterior tooth or teeth are missing in the same arch, no other tooth or teeth are in need of root canal therapy, and no other tooth or teeth are indicated for extraction. If the denial of the root canal and the resultant tooth extraction qualifies the recipient for a partial denture, and the recipient did not previously qualify for a partial denture, the root canal can be approved.

4. Good recipient attendance record.

Exceptions can be made in the following cases, as determined by the dental consultant:

- Recipients who have post-radiation necrosis potential.
- Blood diseases or disorders where extractions are contraindicated.
- Medically compromised or handicapped recipients.
- Recipients unable to wear complete or partial denture for documented psychiatric reasons.
- Unusual clinical situation where an endodontic procedure appears appropriate based on comprehensive review of the dental plan and medical history. (For example, an irreversible pulpotomy caused by a deep restoration with no other tooth loss within the last three years.).
- Recipients under age 21 who may require more than two molar root canals.
- Recipients under age 21 who may also require a partial denture to replace a missing anterior tooth or teeth.
- To preserve the integrity of an intact arch or quadrant.

CRITERIA USED FOR EVALUATION OF ROOT CANAL THERAPY PRIOR AUTHORIZATION REQUEST

The following criteria are used to evaluate PA requests for root canal therapy:

- Root canal therapy should not be considered for a Medicaid recipient if restoration requires a post and core unless the recipient pays for the post and core. Post and core is not a covered service. If the recipient is unable to pay for the post and core, root canal therapy should not be requested.
- Oral health status and x-rays do not indicate rampant decay; only three anterior teeth or only one bicuspid or molar root canal is necessary.
- Root canal therapy is *not* covered on third molars.
- Root canals performed in anticipation of overlay dentures are not covered.

CRITERIA FOR APICOECTOMY

- An apicoectomy procedure can be approved when an anterior tooth with a failing root canal can be made clinically functional by the procedure.

Appendix 12
Endodontic Services
(continued)

MISSING TEETH EXCLUSIONS

Wisconsin Medicaid's definition of missing teeth *excludes*:

- Wisdom teeth.
- Teeth previously extracted for orthodontic reasons.
- Congenitally missing teeth.
- Teeth lost due to trauma, cancer, or rare tumor.

PRIOR AUTHORIZATION DOCUMENTATION

The provider must submit the following information for root canal therapies:

- Complete intraoral tooth charting and periodontal case type.
- Minimum of two bitewing x-rays and periapical x-ray of involved tooth or teeth.
- Attendance information.
- Indication of oral hygiene status.
- Date and reason for any extractions within the past three years.
- A treatment plan including plan for involved tooth or teeth.
- A good success potential for:
  1. Proper completion of the procedure.
  2. Restoration of the tooth.
  3. Maintenance of the endodontically treated tooth (recipients will maintain their oral health).

DENIAL OF ROOT CANAL THERAPY REQUESTS

If the PA request for root canal therapy is denied, the service is noncovered. The recipient:

- Must be informed in advance of treatment that the service is noncovered.
- May be billed for the service only if PA has been denied and the recipient agrees to pay for the service before the service is provided.

Refer to Section VIII of Part A, the all-provider handbook, for more information.

WISCONSIN MEDICAID NONCOVERED MATERIAL AND SERVICES

Wisconsin Medicaid does not cover the following:

- Filling material not accepted by the federal Food and Drug Administration (FDA) (e.g., Sargenti filling material).
- Root canals performed in anticipation of overlay dentures.
- Post and core. Wisconsin Medicaid covers a root canal needing a post and core only if the recipient agrees in advance to pay for the post and core.

Appendix 12
Endodontic Services
(continued)

BILLING

EMERGENCY SERVICES

Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, or trauma. Because the ADA claim form does not have an element to designate emergency treatment, all claims for emergency services must be identified by an "E" in the "For Administrative Use Only" box on the line item for the emergency service of the ADA claim form or element 24I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. *Only the letter "E" without any additional letters is accepted.* Information relating to the definition of a dental emergency is in Section II-A of this handbook.

EMC claims use a different field to indicate an emergency. Refer to your EMC manual for more information.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered endodontic services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.

Appendix 13
Periodontic Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Surgical Services (including usual postoperative services):				
04210	Gingivectomy or gingivoplasty - per quadrant	Yes	All	Per quadrant of six teeth or more.
04211	Gingivectomy or gingivoplasty, per tooth	Yes	All	Less than six teeth (tooth numbers 1-32, A-T, SN).
04341	Periodontal scaling and root planing, per quadrant	Yes	>12	Per quadrant of eight teeth. (Limited in most circumstances to once per three years per quadrant.) Limited to two quadrants per day in place of service 0, 3, 4, 7, or 8, unless the PA request provides sound medical or other logical reasons, including long distance travel to the dentist or disability makes travel to dentist difficult. Up to four quadrants per day, per recipient in place of service 1, 2, or B. Not billable with prophylaxis.
04355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis	Yes	>12	Full mouth code. Excess calculus must be evident in x-ray. Billed on completion date only. Can be completed in one long appointment. No other periodontal treatment (04341 or 04910) can be authorized immediately after this procedure. Includes tooth polishing. Not billable with prophylaxis. (Once per three years in most circumstances.)

Appendix 13
Periodontic Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
04910	Periodontal maintenance procedures (following active therapy)	Yes	>12	Prior authorization may be granted up to three years. Not billable with prophylaxis. Once per year in most cases.
W7117	Treat ANUG (acute necrotizing ulcerative gingivitis/Vincent's disease)	No	All	Treatment for any or all portions of the mouth. Not tooth specific. *Emergency only.* Limit of $50.00 per day for all emergency procedures done on a single day. Narrative required to override the limitation.
W7118	Treat periodontal abscess	No	All	Tooth numbers 1-32, A-T, SN. *Emergency only.* Limit of $50.00 per day for all emergency procedures done on a single day. Narrative required to override limitation.

Appendix 13
Periodontic Services
(continued)

COVERED SERVICES

GINGIVECTOMY SERVICES

Gingivectomy/gingivoplasty procedures include:

- All pre-operative diagnosis.
- Periodontal charting.
- Surgery, including local anesthetic, post-operative dressings, and follow-up appointments.

PERIODONTAL SCALING AND ROOT PLANING

The procedure includes all pre-operative diagnosis, periodontal charting, treatment, local anesthetic, and post-operative follow-up.

FULL MOUTH DEBRIDEMENT

This scaling procedure is more precise in describing therapy for generalized gingivitis and is not meant to be performed on a routine basis. On completion of treatment, the gingival tissues should be normal and can be maintained by adult prophylaxes on a regular basis. The procedure includes tooth polishing. It is not allowed on the same day as prophylaxes.

PERIODONTAL MAINTENANCE PROCEDURES (FOLLOWING ACTIVE THERAPY)

This procedure follows active periodontal treatment. It includes:

- An update of the medical and dental histories.
- Radiographic review.
- Extraoral and intraoral soft tissue examination.
- Dental examination.
- Periodontal evaluation.
- Removal of the bacterial flora from crevicular and pocket areas.
- Scaling and root planing where indicated.
- Polishing of the teeth.
- A review of the recipient's plaque control efficiency.

Periodontal maintenance is not allowed on the same day as prophylaxes but can be alternated with the prophylaxis procedure to allow the patient to be seen every six months for prophylaxes following active therapy for up to three years following active periodontal treatment.

QUADRANTS

Wisconsin Medicaid defines one quadrant of periodontal procedures as involving eight teeth, regardless of their actual location. For example, periodontal scaling and root planing of two teeth in each of four anatomic quadrants (mandibular left, mandibular right, etc.) constitutes one quadrant of periodontal therapy for approval and reimbursement guidelines.

Four quadrants per day are allowed in inpatient and outpatient hospital and ambulatory surgical center settings. In other settings, only two quadrants are allowed in a day. However, if the recipient has difficulty traveling to dental appointments or if medical or other reasons are *indicated on the prior authorization (PA) request*, then PA for scaling and root planing may be approved up to four quadrants per day, per recipient.

Appendix 13
Periodontic Services
(continued)

PRIOR AUTHORIZATION

PRIOR AUTHORIZATION FOR PERIODONTIC SERVICES

Generally, gingivectomy procedures are approved if greater than 25 percent of the crown is covered with hyperplastic gingiva, and the recipient has a history of medication-induced hyperplasia, puberty gingivitis, familial hereditary hyperplasia, or irritation from orthodontic treatment.

Periodontal scaling and root planing procedures are approved when the periodontal charting demonstrates periodontal pocketing between 4mm and 6mm in depth and history of bleeding, swollen, or infected periodontium (gums). A dental history of long-standing chronic inflammation is not an acceptable criteria for periodontal scaling and root planing.

Periodontal maintenance procedures can be prior authorized:

- Along with the request for scaling and root planing.
- After scaling and root planing has been completed.

Periodontal maintenance procedures are to be alternated with prophylaxes to maintain good oral health for a period of three years following active periodontal therapy.

PRIOR AUTHORIZATION DOCUMENTATION

When submitting PA requests for periodontic services, the following information needs to be included:

- Complete periodontal charting of oral cavity.
- Significant medical and dental history.
- Comprehensive treatment plan for periodontal disease, including treatment, surgery, and postoperative care, including additional prophylaxes as needed.

BILLING

All services done on the same day must be billed on the same claim form. If two claims are submitted, one claim will be denied as a duplicate.

BILLING

EMERGENCY SERVICES

Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, or trauma. All claims for emergency services must be identified by an "E" in the "For Administrative Use Only" box on the line item for the emergency service of the ADA claim form or element 24I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. *Only the letter "E" without any additional letters is accepted*. Information relating to the definition of a dental emergency is in Section II-A of this handbook.

Claims submitted electronically use a different field to indicate an emergency. Refer to your Electronic Media Claims (EMC) manual for more information.

Appendix 13
Periodontic Services
(continued)

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered periodontic services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.